| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155712 | A. BUILDING 00<br>B. WING | 06/15/2011 |

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| COVERED BRIDGE HEALTH CAMPUS | 1675 W TIPTON ST<br>SEYMOUR, IN47274 |

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| F0000 | This visit was for the Recertification and State Licensure Survey.<br><br>Survey dates: June 13, 14, and 15, 2011<br><br>Facility number: 003342<br>Provider number: 155712<br>AIM number: 200403740<br><br>Survey team:<br>Melinda Lewis, RN TC<br>Marla Potts, RN<br>Sharon Whiteman, RN<br><br>Census bed type:<br>SNF: 19<br>SNF/NF: 37<br>Residential: 32<br>Total: 88<br><br>Census payor type:<br>Medicare: 19<br>Medicaid: 24<br>Other: 45<br>Total: 88<br><br>Sample: 14<br>Residential sample: 8<br><br>These deficiencies also reflect state findings in accordance with 410 IAC 16.2. | F0000 | The submission of this Plan of Correction does not indicate an admission by Covered Bridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Covered Bridge Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).To this end, this Plan of Correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| | Quality review completed 6/21/11 by Jennie Bartelt, RN. | | | |
| F0157 SS=D | A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).<br><br>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.<br><br>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.<br>Based on interview and record review, the facility failed ensure timely follow up with the resident's physician to be sure he received a faxed notification and request for change in treatment related to weight | F0157 | F 157 Resident 33 suffered no ill effects from the alleged deficient practice.**Completion Date 7-13-2011** All other residents have the potential to be affected by the deficient practice and | 07/13/2011 |

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| | loss for 1 of 5 residents reviewed for a weight change in a sample of 14.<br><br>Resident # 33<br><br>Findings include:<br><br>The clinical record for Resident # 33 was reviewed on 6/13/11 at 10:45 A.M. The record indicated Resident # 33 has diagnoses that included but was not limited to chronic anemia and macular degeneration. The MDS [minimum data set] assessment, dated 3/24/11, indicated Resident # 33 had moderately impaired cognition. Resident # 33 had weight loss and was not on a planned weight loss program.<br><br>A. A Weight Notification Form, dated 3/10/11, indicated, "...3/5 165.4. 2/27 170.4. 2/20 174.2. 2/13 174.6. Interventions: 2-cal 120 cc tid [three times daily]. Appetite is poor at times. Eats very well et other times. (sic) Accepts 2 cal with med [medication] pass. Has increase and decrease of edema daily. Takes Lasix (water pill) 80 mg BID [two times daily]. Recently diagnosed with Baker's cyst behind R [right] knee, but currently no c/o [complaints of] pain, although he's quit ambulating per self. May we have an order for Remeron (antidepressant) 7.5 mg Qhs [every bedtime] for appetite | | through alterations in processes and in-servicing will ensure timely physician notification. **Completion Date 7-13-2011** All nurses have been in-serviced concerning the campus procedure for physician notification guidelines. Systemic change is the nurses will review all outstanding faxes at change of shift and document on 24 hour report to assure timely physician notification. **Completion Date 7-13-2011** DHS/designee will review 3 random outstanding faxes to ensure physician notification is timely 5x a week for a month then 3x week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 7-13-2011** | |

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| | stimulant?..."<br><br>A Physician order, dated 3/18/11 at 2:30 P.M., indicated, "N.O. [new order] Remeron 7.5 mg P.O. [by mouth] QHS appetite stimulant."<br><br>The nurses notes lacked any documentation the physician was contacted by fax or phone between 3/10 to 3/18/11, when a physician order was obtained.<br><br>B. A Weight Notification Form, dated 4/20/11, indicated, "...4/17/11 169.8. 4/10/11 170.4. 4/3/11 171. Interventions: 2-cal 120 cc tid. Sugar free Mighty Shakes BID [two times daily] Remeron 7.5 mg Qhs. Appetite remains extremely poor. Frequently refuses supplements. Res [resident] continues to c/o pain "10" to BLE [bilateral lower extremities]. Currently on PT [physical therapy] for strengthening/transfers. Is requiring 2 max [maximum] assist. May we D/C [discontinue] Remeron and start Megace 400 mg for appetite? Would you like any pain meds ordered? med list to follow...."<br><br>C. A Weight Notification Form, dated 4/27/11, indicated, "...4/24/11 165.8. 4/17/11 169.8. 4/10/11 170.4. 4/3/11 171. Interventions: 2-cal 120 cc tid. Sugar free Mighty Shakes BID [two times daily] | | | |

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| | Remeron 7.5 mg Qhs. Appetite remains extremely poor. Frequently refuses supplements. Res [resident] continues to c/o pain "10" to BLE [bilateral lower extremities]. Currently on PT [physical therapy] for strengthening/transfers. Is requiring 2 max [maximum] assist. Had 2 units RPBC [red packed blood cells} 4/26/11 May we D/C [discontinue] Remeron and start Megace 400 mg for appetite? Would you like any pain meds ordered? sending med list...."<br><br>A Physician order, dated 5/3/11, indicated, "1. DC [discontinue] Remeron. 2. Megace 400 mg po QD [everyday]. 3. Tylenol 500 mg ii [two] po BID."<br><br>The nurses notes lacked any documentation of the physician being contacted by fax or phone between 4/20 to 5/3/11, when a physician order was obtained.<br><br>The Assistant Director of Nursing provided the facility policy and procedure for physician notification guidelines, dated 12/6/07, on 6/14/11 at 11:30 A.M. The policy indicated, "...If the facility has not had a response to abnormal test results or request for physician intervention within 12 hours or notmal test results within 72 hours, the nurse on duty will call the physician to obtain further | | | |

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| | instructions. Attempts to notify the physician and their response should be documented in the resident record....If the attending physician does not respond to notification attempts after three phone calls the Medical Director and Director of Health Services should be notified for further instructions."<br><br>In an interview with the Assistant Director of Nursing, on 6/14/11 at 11:15 A.M., she indicated Resident # 33's physician is hard to get to respond, and the Medical Director doesn't like to override other physicians with orders.<br><br>3.1-5(a)(3) | | | |
| F0250 SS=D | The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.<br>Based on observation, interview and record review, the facility failed to ensure Resident # 28 received social services to assist with her anxiety instead of medicating the resident for the anxiety, for 1 of 12 residents reviewed for medications in the sample of 14. Resident #28 | F0250 | **F 250** Resident #28 suffered no ill effects from the alleged deficient practice.**Completion Date 7-13-2011** All residents have the potential to be affected by the alleged deficient practice and therefore through alterations in processes and in- servicing the campus will ensure it provides medically-related social services to attain or maintain the highest | 07/13/2011 |

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| | Findings include:<br><br>Resident #28 was identified by RN #1, the Assistant Director of Nursing, on 6/13/11 at 10:00 A.M., as cognitively impaired, requiring a Hoyer lift for transfers and being bedfast. The resident was observed lying in bed at the time of the tour.<br><br>Resident #28's clinical record was reviewed on 6/14/11 at 10:00 A.M. The MDS (Minimum Data Set) assessment, dated 3/18/11, indicated the resident was severely cognitively impaired, with altered level of consciousness constantly (startled easily, repeatedly dozed off, difficult to arouse), behaviors of (other behaviors not directed towards other, e.g. hitting, scratching self, verbal/vocal symptoms), and these behaviors did not impact the resident or others.<br><br>A Care Plan problem, dated 3/11 and updated 6/7/11, indicated, "mood, anxious appearance as evidenced by episodes of anxiety, and anti anxiety medication in place, related to history of anxiousness and new environment for resident." Interventions included: "report to MD changes in mood status, monitor effectiveness of medications as ordered-see current physician orders."<br><br>Physician orders, dated 6/5/11, included | | practicable physical, mental, and psychosocial well-being of each resident.**Completion Date 7-13-2011** All campus staff has been in serviced on need of when to notify social services. Campus nurses have been in serviced on using the new assessment titled Mental Wellness Circumstance, Assessment and Intervention form when a new or an exacerbation of a behavior occurs.Systemic change will include completing the Mental Health Wellness Circumstance, Assessment, and Intervention form when a new or an exacerbation of a behavior occurs. Systemic change will also include SSD to review all new medication orders daily. **Completion Date 7-13-2011** SSD and /or designee will print group behavior detail report daily to assure the Mental Health Wellness Circumstance, Assessment, and Intervention form was completed when indicated to assure behaviors and psychosocial needs were documented, monitored, and addressed. Results of daily audits will be forwarded monthly to QA for 6 months and quarterly thereafter for further suggestion/recommendations based on compliance. **Completion Date 7-13-2011** | |

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| | an order, which was started on admission 3/11/11, for "Alprazolam .25 mg, give one tablet per peg tube (gastrostomy tube) every 6 hours as needed for anxiety."<br><br>Medication Administration Records for May 2011 and June 1 to 13, 2011, and the PRN (as needed) Medication Tracking Forms indicated the Alprazolam was given on the following dates: 5/4/11 7:30 p.m., 5/5/11 7 p.m., 5/6/11 7 p.m., 5/8/11 8 a.m. and 6 p.m., 5/9/11 8 a.m. and 8 p.m., 5/11/11 7 p.m., 5/12/11 7 p.m., 5/14/11 7 p.m., 5/15/11 7 p.m., 5/21/11 11 p.m., 5/23/11 1 a.m. and 9 p.m., 6/3/11 11 p.m., 6/5/11 1 a.m., and 6/13/11 7 a.m. The PRN Medication Tracking Form indicated the reason given for each dose was "2." The instructions indicated "2" was anxiety (pacing, hand wringing, rocking, expressions of anxiety, etc.). There were three interventions documented as tried before the medication was given. The three interventions were a combination of the following: "2-bedrest, 5-diversion, 10-social service intervene, 14-reassurance, 15-position for comfort, and 13-one on one time."<br><br>Nurses Notes dated from 4/23 through 6/13/11, lacked any documentation of anxiety or what the resident was doing prior to the administration of the Alprazolam. The Skilled Nursing | | | |

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| | Assessment and Data Collection Forms, dated daily 5/9/11 through 6/13/11, did not include any documentation under the box labeled "mood and behavior, check all that apply." Areas to check included, but were not limited to: "trouble falling or staying asleep, fidgeting/restless, lethargic, behavior interfere with social interactions, disrupt environment, resident rejects care...."<br><br>The Social Service Progress Notes, included entries dated 3/12/11 and 5/4/11. The 3/12/11 entry included: "resident takes Alprazolam .25 mg every 6 hours prn (as needed) for anxiety." The 5/4/11 entry indicated the resident was adjusting to new room and "res voices no concerns and says yes to being pleased with new room." There were no notes concerning the resident's being anxious.<br><br>During interview with RN #1 on 6/14/11 at 10:00 A.M., she indicated the facility used a behavior book for residents with behaviors. She indicated Resident #28 was not included in the book, and that social services created the plans in the book.<br><br>During interview with the Social Service Director on 6/14/11 at 10:05 A.M., she indicated the resident did not currently have anxiety. She indicated she was not | | | |

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| | aware staff were giving the as needed Alprazolam or what the resident's symptoms were.<br><br>During interview with LPN #3 on 6/14/11 at 1:15 p.m., she indicated she worked evening shift and had administered the Alprazolam several times in May 2011. She indicated the resident was restless, on her call light several times, would not use her communication board and staff were unable to figure out what the resident wanted. She indicated she felt the resident was much better at this time, and she had not given the drug since mid May.<br><br>3.1-34(a) | | | |

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| F0279 SS=D | A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br>Based on interview and record review, the facility failed to develop an individualized plan to assist Resident #28 with increased anxiety using non-pharmacological interventions based on the resident's symptoms, for 1 of 12 residents reviewed for medications in the sample of 14. Resident #28<br><br>Findings include:<br><br>Resident #28 was identified by RN #1, the Assistant Director of Nursing, on 6/13/11 at 10:00 A.M., as cognitively impaired, requiring a Hoyer lift for transfers and being bedfast. The resident was observed lying in bed at the time of the tour. | F0279 | F 279<br><br>Resident #28's care plans have been reviewed and updated as applicable<br><br>**Completion Date 7-13-2011**<br><br>All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the campus will ensure the resident's plan of care is current.<br>**Completion Date 7-13-2011**<br><br>An in-service was provided to nursing staff concerning non-pharmacological interventions for residents with behaviors and care | 07/13/2011 |

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| | Resident #28's clinical record was reviewed on 6/14/11 at 10:00 A.M. The MDS (Minimum Data Set) assessment, dated 3/18/11, indicated the resident was severely cognitively impaired, with altered level of consciousness constantly, (startled easily, repeatedly dozed off, difficult to arouse), behaviors of (other behaviors not directed towards other, e.g. hitting, scratching self, verbal/vocal symptoms), and these behaviors did not impact the resident or others.<br><br>A Care Plan problem, dated 3/11 and updated 6/7/11, indicated, "mood, anxious appearance as evidenced by episodes of anxiety and anti anxiety medication in place, related to history of anxiousness and new environment for resident." Interventions included: "report to MD changes in mood status, monitor effectiveness of medications as ordered-see current physician orders."<br><br>Physician orders, dated 6/5/11, included an order, which was started on admission 3/11/11, for "Alprazolam .25 mg give one tablet per peg [gastrostomy] tube every 6 hours as needed for anxiety."<br><br>Medication Administration Records for May and June 1 to 13, 2011 and the PRN Medication Tracking Forms indicated the | | plans. Systemic change is a copy of the care plan for residents with active behaviors will be kept in the front of the resident's specific medication administration sheet.<br>**Completion Date 7-13-2011**<br><br>DHS/designee will perform audits of 2 random residents with behaviors to assure care plans are current and in place 5x week x one month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments<br>**Completion Date 7-13-2011** | |

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| | Alprazolam was given on the following dates: 5/4/11 7:30 p.m., 5/5/11 7 p.m., 5/6/11 7 p.m., 5/8/11 8 a.m. and 6 p.m., 5/9/11 8 a.m. and 8 p.m., 5/11/11 7 p.m., 5/12/11 7 p.m., 5/14/11 7 p.m., 5/15/11 7 p.m., 5/21/11 11 p.m., 5/23/11 1 a.m. 9 p.m., 6/3/11 11 p.m., 6/5/11 1 a.m., 6/13/11 7 a.m. The PRN Medication Tracking Form indicated the reason given for each dose was "2." The instructions indicated "2" was anxiety (pacing, hand wringing, rocking, expressions of anxiety, etc.). There were three interventions documented as tried before the medication was given. The three interventions were a combination of the following: "2-bedrest, 5-diversion, 10-social service intervene, 14-reassurance, 15-position for comfort, 13-one on one time."<br><br>Nurses Notes dated from 4/23 through 6/13/11 lacked any documentation of anxiety or what the resident was doing prior to the administration of the Alprazolam. The Skilled Nursing Assessment and Data Collection Forms dated 5/9/11 daily through 6/13/11, did not include any documentation under the box labeled mood and behavior, check all that apply. Areas to check included but were not limited to: "trouble falling or staying asleep, fidgeting/restless, lethargic, behavior interfere with social interactions, disrupt environment, resident | | | |

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rejects care...."

The Social Service Progress Notes, included entries dated 3/12/11 and 5/4/11. The 3/12/11 entry included: "resident takes Alprazolam .25 mg every 6 hours prn (as needed) for anxiety." The 5/4/11 entry indicated the resident was adjusting to new room and "res voices no concerns and says yes to being pleased with new room." There were no notes concerning the resident's being anxious.

During interview with RN #1 on 6/14/11 at 10:00 A.M., she indicated the facility used a behavior book for residents with behaviors. She indicated Resident #28 was not included in the book, and that social services created the plans in the book.

During interview with the Social Service Director, on 6/14/11 at 10:05 A.M. she indicated the resident did not currently have anxiety. She indicated she was not aware staff were giving the as needed Alprazolam or what the resident symptoms were.

During interview with LPN #3, on 6/14/11 at 1:15 p.m., she indicated she worked evening shift and had administered the alprazolam several times in May 2011. She indicated the resident

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| | was restless, on her call light several times, would not use her communication board and staff were unable to figure out what the resident wanted. She indicated she felt the resident was much better at this time and she had not given the drug since mid May.<br><br>3.1-35(b)(1) | | | |
| F0323<br>SS=E | The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview, and record review, the facility failed to ensure residents with a history of falls received staff supervision to ensure alarms were responded to in time to prevent falls, alternate interventions were implemented when alarms failed to prevent falls, and the planned interventions to prevent falls were implemented for 4 of 8 residents reviewed for falls in a sample of 14.<br><br>Residents # 26, #23, #33, #39 | F0323 | F 323<br><br>Resident #'s 23,26,33, and 39 plan of care related to risk for falls has been reviewed and updated as necessary and staff has been in- serviced on this plan of care.<br>**Completion Date 7-13-2011**<br><br>All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in-servicing the campus will ensure that the resident environment remains as free of accident hazards | 07/13/2011 |

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| | Findings include:<br><br>1. During interview on the initial tour on 6/13/11 at 9:30 A.M., the Director of Nursing indicated Resident # 26 was not interviewable and had recent fall. Resident # 26 was observed at the time to be in a bedside recliner asleep.<br><br>On 6/13/11 at 1:35 P.M., Resident # 26 was observed to be asleep in a bedside recliner in her room. Resident # 26's wheelchair was observed to be sitting in front of the resident.<br><br>On 6/13/11 at 2:50 P.M., Resident # 26 was observed to be asleep in a bedside recliner in her room. Resident # 26's wheelchair was observed to be sitting in front of the resident.<br><br>On 6/13/11 at 4:30 P.M., Resident # 26 was observed to be asleep in a bedside recliner in her room. Resident # 26's wheelchair was observed to be sitting in front of the resident.<br><br>On 6/14/11 at 8:40 A.M., Resident # 26 was observed to be asleep in her wheelchair in the hallway.<br><br>The clinical record for Resident # 26 was reviewed on 6/13/11 at 3:20 P.M. The | | as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br>**Completion Date 7-13-2011**<br><br>Nursing staff have been in-serviced concerning Fall/Safety Management. Systemic change is the C.N.A. Assignment sheet that communicates to the C.N.A. fall and safety interventions will be updated after IDT reviews 5x week, and a new intervention is put in place.<br>**Completion Date 7-13-2011**<br><br>DHS /designee will monitor 3 random resident at risk for falls to assure safety interventions in place as per plan of care and staff following plan of care to prevent an accident 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments<br>**Completion Date 7-13-2011** | |

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| | record indicated Resident # 26 had diagnoses that included but were not limited to dementia. The MDS [Minimum Data Set] assessment, dated 4/8/11, indicated Resident # 26 had severely impaired cognition. Resident # 26 required extensive assistance of one with bed mobility, extensive assistance of two with transfers and toilet use and did not ambulate. Resident # 26 had fallen since the previous assessment one fall with injury and one fall resulted in major injury.<br><br>The Nurses Notes, dated 2/23/11 at 10:45 P.M., indicated, "Res [resident] found by writer lying on floor on R [right] side of body. Res 2 assist back to w/c. Res claims she was trying to go to restroom. Various items scattered in floor, inadequate lighting, call light within reach but not used. Res did not have glasses on. No footwear...Res offered/assisted to restroom Q [every] 2 hours to decrease chances of falling again..."<br><br>A Fall Circumstance Assessment and Intervention, dated 2/23/11, indicated, "...Prevention Update- Started neuro checks, Frequently used items within reach, Toilet Q 2 hours assist, Adequate lighting, glasses in place. IDT [Interdisciplinary Team] Review- IDT review of above prevention update agrees | | | |

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| | as appropriate to maximize safety- N [no]. Date of review 2-24-11. IDT review recommends the following change to prevention update: Toilet Q 2 hours at night..."<br><br>The Nurses Notes, dated 2/24/11 at 10:20 P.M., indicated, "CNA alerted writer and fellow nurse to res doorway. Res was found sitting next to her w/c on her buttocks up against the wall. Res had just been observed by the CNA propelling self out her doorway and looking around as CNA proceeded to enter neighboring room she heard a thump sound exited the room and found resident. Res exhibiting increased confusion and drowsiness in general typical sx [symptoms] for her when she has a UTI [urinary tract infection] and res is currently receing (sic) po [by mouth] Atb [antibiotic] to treat such. Res alert answers questions appropriately...Res denies pain 2 staff assisted res up and into her w/c. Res bears full wt [weight] well without obvious injuries or pain. Res assisted to restroom and then to bed...Call light at side within reach. Res assures staff she will call for assist before getting up..."<br><br>A Fall Circumstance Assessment and Intervention, dated 2/24/11, indicated, "...Prevention Update- Orient to environment, Toilet Q 2 hours assist/cues, | | | |

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| | Adequate lighting, glasses in place, teach w/c safety. IDT [Interdisciplinary Team] Review- IDT review of above prevention update agrees as appropriate to maximize safety- N [no]. Date of review 2-25-11. IDT review recommends the following change to prevention update: Will request urine C & S [culture and sensitivity] Tylenol PM to establish sleep pattern..."<br><br>The Nurses Notes, dated 3/27/11 at 2:00 A.M., indicated, "Writer answered call light entered the room and found res sitting on her buttocks with her legs extended towards her roommates HOB [head of bed]. Res states she fell out of bed while asleep she knows she hit her head and thinks it was on the floor but she isn't sure. Res noted to have a 4 x [by] 2 cm dk [dark] purple hematoma on her R [right] forehead extending up into the hairline...Res c/o [complains of] mild pain with her left foot/ankle. Res states it is sore when area palpated mild purple discoloration observed in the L [left] foot/ankle outer region. Res assisted to feet with staff assistance then to bed and ice pack applied to R forehead hematoma..."<br><br>The Nurses Notes, dated 3/27/11 at 2:30 A.M., indicated, "Dr (name) notified via phone injuries described MD stated observe overnight and see how she is in | | | |

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| | the morning."<br><br>The Nurses Notes, dated 3/27/11 at 8:30 A.M., indicated, "CNA reported to this writer that she was un able to put res shoe on r/t [related to] swelling/pain. Upon assessment to L foot with bluish/purple bruising measuring 6.0 cm x 5.0 cm. Res c/o pain with any movement/touch. Area is swollen. Dr (name) notified N.O. [new order] rec'd [received] for x-ray L foot/ankle..."<br><br>The Nurses Notes, dated 3/27/11 at 2:10 P.M., indicated, "Xray results received...Lt [left] foot xray shows 4th et [and] 5th metatarsal [toes] neck fractures..."<br><br>A Fall Circumstance Assessment and Intervention, dated 3/27/11, indicated, "...Prevention Update- neuro checks per facility policy, glasses in place, sensor alarm. IDT [Interdisciplinary Team] Review- IDT review of above prevention update agrees as appropriate to maximize safety- Y [yes]. Date of review 3/28/11. IDT review recommends the following change to prevention update: Toilet Q 2 hours at night..."<br><br>The Nurses Notes, dated 4/15/11 at 1:30 A.M., indicated, "Res calling out help help from her room at 12:30 am, bed | | | |

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| | alarm sounding writer and CNA were hurrying to res room Res lying in floor beside bed on her left side. Res states I fell when I was getting up to answer the phone...Res has small R [red] area on L side of head, bruise 2 cm x 1 cm on R shoulder and skin tear on left lower leg approx [approximately] 1.5 cm...Res was assisted up via ii [two] assist and taken to nurses station for observation...Res sat at nurses station for 1 hour then asked to go back to bed. Res assisted to bed by writer. Bed alarm on and functioning call light within reach and res educated to use call light. Res states sometimes I can't see it call light fastened to res blankets and res is holding call light at this x [time]."<br><br>The Nurses Notes, dated 4/15/11 at 8:00 A.M., indicated, "Intervention for fall: low bed and glow in the dark call light..."<br><br>A Fall Circumstance Assessment and Intervention, dated 4/15/11, indicated, "...Prevention Update- neuro checks per protocol, alarming bed mat. IDT [Interdisciplinary Team] Review- IDT review of above prevention update agrees as appropriate to maximize safety- N [no]. Date of review 4/15/11. IDT review recommends the following change to prevention update: Res will be placed in a low bed and given glow in the dark call light..." | | | |

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The Nurses Notes, dated 4/28/11 at 3:00 A.M., indicated, "Writer informed of Res on floor by CNA. upon entering res rm CNA et [and] RN already present. Res found lying with feet in bed et head in recliner sliding onto floor. CNA reports res lying on back with pillow behind head in floor. Res was 2 staff assist back into bed. No injury observed at this time. Denies pain...Res cannot verbalize to staff as to reason she fell...all safety devices in place et functioning at time of fall..."

A Fall Circumstance Assessment and Intervention, dated 4/28/11, indicated, "...Prevention Update-neuro checks per protocol, Room close to nursing station, bed in low position, 2 hour safety checks, 2 hour staff assist toileting, staff inservice on keeping bed in low position. IDT [Interdisciplinary Team] Review- IDT review of above prevention update agrees as appropriate to maximize safety- N [no]. Date of review 4/28/11. IDT review recommends the following change to prevention update: moved closer to nurses desk. staff education on proper positioning of low beds. D/C [discontinue] 2 hour safety checks..."

A time line provided by the Director of Nursing, on 6/14/11 at 8:45 A.M., indicated the family refused the

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| | suggestion for resident to be moved closer to the nurses station.<br><br>The Nurses Notes, dated 6/10/11 at 9:20 P.M., indicated, "Res noted on floor between recliner and wheelchair. Res was transferring self from recliner to w/c. Res denies pain no visible injuries...Alarm placed in recliner..."<br><br>2. During interview on the initial tour on 6/13/11 at 9:30 A.M., the Director of Nursing indicated Resident # 23 was not interviewable and had a recent fall.<br><br>On 6/13/11 at 1:35 P.M., Resident # 23 was observed to be in a low bed asleep. A mat was observed to be next to the bed.<br><br>On 6/13/11 at 2:50 P.M., Resident # 23 was observed to be in a low bed asleep. A mat was observed to be next to the bed.<br><br>On 6/13/11 at 4:30 P.M., Resident # 23 was observed to be up in a wheelchair. Resident # 23 was observed to be participating in an activity.<br><br>The clinical record for Resident # 23 was reviewed on 6/13/11 at 10:00 A.M. The record indicated Resident # 23 had diagnoses that included but were not limited to Parkinson's disease and dementia. The MDS [Minimum Data Set] | | | |

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| | assessment, dated 4/10/11, indicated Resident # 23 had moderately impaired cognition. Resident # 23 required extensive assistance of two with bed mobility, transfers, and toilet use. Resident # 23 did not ambulate. Resident # 23 had fallen since the previous assessment.<br><br>A Care plan, dated 1/12/11 and updated on 4/14/11, indicated a problem of "At risk for fall/injury AEB [as evidenced by] history of falls, potential for fall R/T [related to] disease process/condition: Parkinsons, dementia, seizure disorder, decreased mobility r/t Parkinsons, Ativan (antianxiety medication) PRN [as needed] Trazadone (antidepressant medication), Use of assistice (sic) devices: high back w/c." The interventions included but were not limited to "Call light within reach, Defined parameter mattress, Referral for screen and treatment as needed."<br><br>The Nurses Notes, dated 1/21/11 at 10:30 P.M., indicated, "Rd [resident] slipped off side of bed denies hitting head and denies pain. No visible injuries at this time..."<br><br>A Fall Circumstance, Assessment and Intervention, dated 1/21/11, indicated, "...Prevention Updated- Toilet q2h [every two hours]...IDT [Interdisciplinary Team] Review- IDT review of above prevention | | | |

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| | update agrees as appropriate to maximize safety- Y [yes]. Date of review- 1-24-11..."<br><br>The fall care plan, dated 1/12/11, was updated on 1/21/11 to include the intervention of "Toilet Q 2 h[every two hours] at noc [night]."<br><br>A Falls Screen, dated 1/24/11, indicated, "...Identification of Risk Factors...Resident is incontinent of bowel/bladder....Resident is confused. Resident is agitated..w/c only doesn't self propel...No. [number] of falls in last 3 months- 4. Location of falls bedroom. Environmental/situational information...most falls occur when pt [patient] needs to use bathroom, attempting to transfer out of bed without assist..."<br><br>The Nurses Notes, dated 4/21/11 at 9:00 P.M., indicated, "Res [resident] found on floor beside bed. Res asking for wife alarm on and in place, not sounding no visible injuries noted...Alarm placed and tested for function alarm is working properly..."<br><br>A Fall Circumstance, Assessment and Intervention, dated 4/21/11, indicated, "...Prevention Updated- Med [medication] review. UA C & S [urinalysis culture and | | | |

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| | sensitivity], if ordered...IDT [Interdisciplinary Team] Review- IDT review of above prevention update agrees as appropriate to maximize safety- Y [yes]. Date of review- 4/22/11. IDT review recommends the following change to prevention update: alarm box/pad replaced..."<br><br>The fall care plan, dated 1/12/11, was updated on 4/21/11 to include the intervention of "UA C & S [urinalysis culture and sensitivity], Med [medication] review , alarm box/pad replaced."<br><br>The Nurses Notes, dated 4/25/11 at 1110 (11:10 A.M.), indicated, "At 9:45 A [a.m.] found res lying on floor on back in front of w/c. Denies pain. Denies hitting head...Assisted back into w/c with assist. Will leave res at ns [nurses station] for safety unless in bed or wife present..."<br><br>A Fall Circumstance, Assessment and Intervention, dated 4/25/11, indicated, "...Prevention Updated- Keep at NS [nurses station] unless in bed or wife present...IDT [Interdisciplinary Team] Review- IDT review of above prevention update agrees as appropriate to maximize safety- Y [yes]. Date of review- 4/26/11..."<br><br>The fall care plan, dated 1/12/11, was | | | |

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| | updated on 4/25/11 to include the intervention of "Keep at nurses station unless in bed or with wife."<br><br>The Nurses Notes, dated 5/1/11 at 9:00 P.M., indicated, "At 6:45 pm rd [resident] found on floor lying on left side. Rd denies hitting head...he was trying to transfer self. Writer asked rd roommate if he assisted rd into room and left rd unattended, rd roommate states "yes he asked to go into the room so I helped" Writer educated roommate about rd needing to be at nurses station unless wife is present..."<br><br>A Fall Circumstance, Assessment and Intervention, dated 5/1/11, indicated, "...Prevention Updated- roommate education...IDT [Interdisciplinary Team] Review- IDT review of above prevention update agrees as appropriate to maximize safety- Y [yes]. Date of review- 5/2/11..."<br><br>The fall care plan, dated 1/12/11, was updated on 5/1/11 to include the intervention of "Roommate education on not pushing resident into room and leaving him alone due to safety."<br><br>The fall care plan, dated 1/12/11, was updated on 5/5/11 to include the intervention of "hi-low bed." | | | |

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| | The Nurses Notes, dated 6/12/11 at 4:30 A.M., indicated, "Res floor alarm sounded, CNA reports res on knees in floor. Writer called to rm [room]. Res observed on floor beside bed knees on mat. 2 staff assist res back to bed. Res states he was trying to go to restroom (Res incont [incontinent] bowel/bladder)...denies pain/distress L [left] knee slightly red from floor...Staff changed res et [and] res continues to try to get out of bed. Brought res to ns [nurses station] with writer. Call light within reach, floor alarm in place et functioning. Res to be offered urinal at night since he states he wants to use restroom. Res at NS at this time with writer eating yogurt..."<br><br>The fall care plan, dated 1/12/11, was updated on 6/12/11 to include the interventions of "Offer urinal at noc [night] and Spoke with res [resident] r/t [related to] wife no being here this past week. Reassured res that wife is receiving the best care possible while at (hospital name)."<br><br>3. On the initial tour, on 6/13/11 at 9:30 A.M., the Director of Nursing indicated Resident # 33 was not interviewable and had no recent falls.<br><br>On 6/13/11 at 12:20 P.M., Resident # 33 was observed to be in a wheelchair sitting | | | |

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| | at the dining room table.<br><br>On 6/13/11 at 1:35 P.M., Resident # 33 was observed to be in a bedside recliner asleep.<br><br>On 6/13/11 at 2:20 P.M., Resident # 33 was observed to be in a bedside recliner asleep.<br><br>On 6/13/11 at 4:30 P.M., Resident # 33 was observed to be up in a wheelchair sitting in the hallway.<br><br>The clinical record for Resident # 33 was reviewed on 6/13/11 at 10:45 A.M. The record indicated Resident # 33 has diagnoses that included, but were not limited to, chronic anemia and macular degeneration. The MDS [Minimum Data Set] assessment, dated 3/24/11, indicated Resident # 33 had moderately impaired cognition. Resident # 33 required supervision of one with bed mobility and transfers. Resident # 33 had fallen since the previous assessment.<br><br>A Care plan, dated 3/25/11 and updated on 5/8/11, indicated a problem of "Falls At risk for fall/injury AEB [as evidenced by] history of falls, Potential for falls R/T [related to] disease process/condition: blindness d/t [due to] macular degeneration, a fib [atrial fibrillation], | | | |

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| | HTN [hypertension], NIDDM [noninsulin dependent diabetes mellitus], medication usage: antidepressants, use of assistice (sic) devices: w/c." The interventions included but were not limited to "Provide environmental adaptations: area free of clutter, call light within reach. Remind resident and reinforce safety awareness. Lock breaks (sic) on bed, chair, etc before transferring."<br><br>The Nurses Notes, dated 4/7/11 at 5:30 P.M., indicated, "Resident found on floor next to wheelchair. Resident stated he was trying to get into wheelchair and his legs got weak. No injury noted, no c/o [complaints of] pain, MD and family notified. Resident reminded to ask for help when transferring self."<br><br>A Fall Circumstance Assessment and intervention, dated 4/7/11, indicated, "...Prevention Update- call bell, wait for help to transfer. IDT [Interdisciplinary Team] review- IDT review of above prevention update agrees as appropriate to maximize safety- No. Date of Review 4/8/11, IDT review recommends the following change to prevention update: up in w/c between 5 P and 6P for meals and encouraged to go to DR [dining room], ii assist with gait belt assist to DR prn [as needed]..." | | | |

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| | The fall care plan, dated 3/25/11, was updated on 4/7/11 to include the intervention of "Res to be up in w/c for meals and encourage res to go to DR for meals."<br><br>The Nurses Notes, dated 4/27/11 at 4:30 P.M., indicated, "Summoned to res [resident] room per CNA noted res on floor in front of bed and recliner states transferring self from w/c to recliner "should have turned L [left] but turned R [right] no injuries noted moves all extremities as before...denies any pain denies hitting head no red or open areas. Assisted from floor to recliner with 2 staff..."<br><br>A Fall Circumstance Assessment and intervention, dated 4/27/11, indicated, "...Prevention Update- teach w/c safety. IDT [Interdisciplinary Team] review- IDT review of above prevention update agrees as appropriate to maximize safety- No. Date of Review 4/28/11, IDT review recommends the following change to prevention update: Velcro belt without alarm to remind res to ask for assist use call light when transferring..."<br><br>The fall care plan, dated 3/25/11, was updated on 4/27/11 to include the intervention of "Velcro belt without alarm to remind res to use call light/request | | | |

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| | assist when transferring."<br><br>The Nurses Notes, dated 5/5/11 at 3:30 P.M., indicated, "Summoned to res room per CNA res on floor on buttocks in front of toilet with back leaning against toilet. States missed w/c and sat self to floor softly...no red or open areas denies pain. assisted to w/c per two staff..."<br><br>A Fall Circumstance Assessment and intervention, dated 5/5/11, indicated, "...Prevention Update- Alarming seat belt. IDT [Interdisciplinary Team] review- IDT review of above prevention update agrees as appropriate to maximize safety- Yes. Date of Review 5/6/11..."<br><br>The fall care plan, dated 3/25/11, was updated on 5/5/11 to include the intervention of "self releasing velcro alarm belt to alert staff of unassisted transfers."<br><br>A Falls Screen, dated 5/6/11, indicated, "...Resident is confused...Resident has visual problems...Resident has history of falls- No. [number] of alls in last 3 months- 5. Location of falls- In room. Environmental/situational information- Pt [patient] self transferring instead of using light for assistance..."<br><br>The Nurses Notes, dated 5/6/11 at 9:00 | | | |

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| | A.M., indicated, "After investigation of fall that occurred on 5/5/11, found that res is not remembering to use call light when removing velcro seat belt. Continues to transfer per self, and has difficulty recalling where w/c is placed and is legally blind. Will place alarm to self releasing velcro belt as enabler to alert staff of unassisted transfers..."<br><br>The Nurses Notes, dated 5/8/11 at 3:25 A.M., indicated, "Res fell at approx [approximately] 3 AM. CNA summoned nurse to room (number). Res lying in floor on his R side with feet out beneath recliner. Draw sheet beneath res buttocks and blankets were at foot of bed. Res states "I was trying to sit up and slipped off of bed into floor." Res denies pain/discomfort. no red areas or injuries noted...assisted back into bed via ii [two] assist 1/2 SR [side rail] down to remind res to use call light to transfer into recliner or w/c. Res verbalized understanding of SR use. Res wishes to stay in bed at this x [time]..."<br><br>A Fall Circumstance Assessment and intervention, dated 5/8/11, indicated, "...Prevention Update- 1/2 SR to remind res to use call light to assist with transfers. IDT [Interdisciplinary Team] review- IDT review of above prevention update agrees as appropriate to maximize safety- No. | | | |

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| | Date of Review 5/9/11, IDT review recommends the following change to prevention update: alarming floor mat while in bed or recliner, will obtain UA C & S [urinalysis with culture and sensitivity] next lab day..."<br><br>The fall care plan, dated 3/25/11, was updated on 5/8/11, to include the intervention of "alarming floor mat while in bed or recliner UA C & S."<br>4. Resident #39 was identified by RN #1 on 6/13/11 at 9:30 A.M. as having had falls, cognitively impaired, and incontinent of urine. The resident was observed at the time of the tour to be in bed with a full mattress beside the bed.<br><br>On 6/13/11 at 3:30 p.m. Resident #39 was observed in the low bed. No mattress was observed down on the floor beside him. Visitors were also observed in the room.<br><br>On 6/14/11 at 1:30 p.m. Resident #39 was observed in his low bed. No mattress was observed on the floor beside the bed. The alarm on the bed was observed to not be connected to the alarm box. The wheelchair was sitting in the room, the seat belt not latched and the alarm on the back of the chair turned off. The wheelchair was facing towards the bathroom and away from the bed. | | | |

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The charge nurse for Resident #39, LPN #1, was notified at 1:35 P.m. of the resident being in bed. She indicated she did not know who put him to bed. CNA #1 indicated at the same time she was the only CNA on Resident #39's hall and she had not placed him in bed. LPN #1 indicated maybe therapy had placed him in bed.

Resident #39's clinical record was reviewed on 6/13/11 at 11:50 p.m. Diagnoses included, but were not limited to: "Dizziness and pneumonia."

The most recent MDS (Minimum Data Set) assessment, dated 3/29/11, an admission assessment, indicated the resident required assistance with transfers and ambulation, had fallen in the past 2 to 6 months, and was moderately cognitively impaired.

The care plan for falls, dated 4/1/11 and updated through 6/11, included a problem of " falls at risk for injury related to history of falls and potential of falls, related to disease process/condition, dizziness, depression, functional problem, decreased mobility, instability, use of assistance devices, wheelchair, walker with assist." The goal was the resident will have reduced risk of fall related

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| | injury by utilizing fall precautions. Interventions included: "report falls to MD/responsible party," "monitor for side effects of any drug that can cause gait disturbance, orthostatic hypotension, weakness, sedation, vertigo, change in mental status (if noted, report to RN), Report to MD any negative side effects and associated with residents medication use, Provide environmental adaptions: low/platform bed, half rails as enabler, call light in reach, adequate glare free lighting, area free of clutter, Provide/monitor use of adaptive devices-walker/cane with assist, wheelchair, remind resident and reinforce safety awareness, lock breaks on bed, chair etc before transferring, educate resident to request assistance prior to ambulation, appropriate footwear, escort to activity programs, safety measures to reduce falls, Additional approaches: mattress next to bed, 4/18/11-educate staff res needs stand by assist with showers, 5/18/11- res education on requesting assist, chest x-rays of ribs, non skid footwear, 5/20/11- bed/chair alarm, 5/28/11 ensure glasses are within reach, bed in lowest position, 6/2/11-self releasing Velcro alarm bed as enabler, 6/3/11 bed against wall.<br><br>Nurses notes and the fall circumstance/assessment and intervention | | | |

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| | forms indicated the following:<br><br>On 4/18/11 at 3:15 p.m., the resident had a fall in the shower, staff were educated to stay with him during the shower. Staff had indicated he had asked them to give him privacy.<br><br>"5/18/11 at 7 p.m. CNA walking by room and noted the resident down on one knee, between the bed and a/c (air conditioner) CNA into help res when stated he thought he dropped a book and was looking for it denied that he fell, CNA went to get a nurse, when nurse assessed res she noted abrasions to left back 13 cm by 1 cm, 6 cm by .8 cm, 4 cm by .8 cm and a skin tear to left elbow 2 by 2 cm, nurses then asked again in he had fallen when he stated 'yes but don't tell anyone' Nurse explained to res that when a fall occurs she needs to know." The fall circumstance/assessment and intervention form, dated 5/18/11, indicated the resident had improper or ill fitting footwear on, and the prevention update included: non skid footwear and remind to ask for assisted from staff.<br><br>"5/20/11 2:20 A.M. resident put on call light, staff responded to find resident laying on his left side beside his bed with wheelchair at his feet (upright position) Both legs flexed at his knees and | | | |

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| | supporting his weight on his left elbow. Denies pain, denies hitting his head or loss of consciousness...assisted to bed times 2....6 a.m. bed and wheelchair alarm ordered...."<br>The fall circumstance/assessment and intervention form, dated 5/20/11, indicated for prevention update-bed an or chair alarm.<br><br>"5/28/11 12:15 A.M. Resident bed alarm sounded, staff times 2 responded to find resident on his left side on the floor beside his bed. His knees were both flexed and he was leaning on his left elbow. Area was free of clutter. non skid socks in place. Res was not wearing his eyeglasses. His call light was in easy reach on his right side. Lighting in room was appropriate for this time of night semidark with the hall light on...lifted times 2 staff back to bed. Noted 1.3 cm linear skin tear to right wrist...bed alarm in place...."<br>The fall circumstance/assessment and intervention form, dated 5/28/11, at 12:15 A.M. indicated, "ensure glasses are within reach..."<br><br>"5/28/11 5:00 A.M. CNA called writer to room, resident on the floor on both knees beside his bed with elbows on mattress alert...resident had removed his oxygen cannula. bed alarm had not sounded secondary resident elbow being on the | | | |

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| | pad. Assisted back to bed times 2, call light in reach. Bed placed in lowest position which would not cause wheels to unlock...Resident stated he got down on his knees to put 'the pills back in the bottle' no pills present..." The fall circumstance/assessment and intervention form, dated 5/28/11 at 5 a.m. indicated a medication review would be done.<br><br>"5/31/11 7 p.m. res fell from wheelchair hitting head on door resident denies pain abrasion noted to top of head alarm to wheelchair sounding...assisted back to wheelchair with assist of 2...placed at nurses station...." The fall circumstance/assessment and intervention form, dated 5/31/11 at 7 p.m. indicated for prevention update: bedside mat, low bed and placed at nurses desk to monitor."<br><br>"6/2/11 4:40 p.m. res found on floor in room in front of wheelchair stated 'I was trying to get down on the floor to play marbles with the boys...' res assisted to to wheelchair with assist of 2...." The fall circumstance/assessment and intervention form, dated 6/2/11 at 4:40 p.m., indicated, for prevention update "to adjust wheelchair."<br><br>"6/2/11 6:15 p.m. res alarm sounding res on floor res alert with confusion...requesting alarming seat belt | | | |

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| | 155712 | A. BUILDING 00<br>B. WING | 06/15/2011 |

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| | to wheelchair...placed at nurses station 1 on 1...." The fall circumstance/assessment and intervention form, dated 6/2/11 at 6:15 P.M., indicated prevention update, "alarming seat belt." The fall circumstance/assessment and intervention form, for this date and time, indicated for prevention update, "alarming seat belt."<br><br>"6/3/11 at 3:30 A.M. alarm sounded and writer entered room to find res standing at door of his room hold on to the door which was swinging back and forth, writer reached out to take hold of resident seat only caught tail of his sweatshirt before he fell to the floor on his right side...resident turned to knees and pulled himself up on dresser...noted skin tear to right forearm posterior aspect..." The fall circumstance/assessment and intervention form, for this date and time, indicated for prevention update "bed against wall."<br><br>3.1-45(a)(2) | | | |

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| F0329 SS=D | Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br>Based on observation, interview and record review, the facility failed to ensure medications were not administered without adequate indications for use, in that Alprazolam (antianxiety medication) was administered for anxiety, without an individualized plan to attempt non-pharmacological interventions based on the resident's symptoms, for 1 of 12 residents reviewed for medications in the sample of 14. Resident #28<br><br>Findings include:<br><br>Resident #28 was identified by RN #1, the Assistant Director of Nursing, on 6/13/11 | F0329 | F 329<br><br>Resident #28 suffered no ill effects from the alleged deficient practice.<br>**Completion Date 7-13-2011**<br><br>All residents have the potential to be affected by the alleged deficient practice therefore through systemic changes stated below the campus will ensure medications are administered with adequate indications for use.<br>**Completion Date 7-13-2011**<br><br>An in-service was provided to nursing staff concerning non-pharmacological interventions | 07/13/2011 |

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| | at 10:00 A.M. as cognitively impaired, requiring a Hoyer lift for transfers and being bedfast. The resident was observed lying in bed at the time of the tour.<br><br>Resident #28's clinical record was reviewed on 6/14/11 at 10:00 A.M. The MDS (Minimum Data Set) assessment, dated 3/18/11, indicated the resident was severely cognitively impaired, with altered level of consciousness constantly (startled easily, repeatedly dozed off, difficult to arouse), behaviors of (other behaviors not directed towards other, e.g. hitting, scratching self, verbal/vocal symptoms), and these behaviors did not impact the resident or others.<br><br>A care plan problem, dated 3/11 and updated 6/7/11, indicated, "mood, anxious appearance as evidenced by episodes of anxiety and anti anxiety medication in place, related to history of anxiousness and new environment for resident." Interventions included: "report to MD changes in mood status, monitor effectiveness of medications as ordered-see current physician orders."<br><br>Physician orders, dated 6/5/11, included an order, which was started on admission 3/11/11, for "Alprazolam .25 mg give one tablet per peg [gastrostomy] tube every 6 hours as needed for anxiety." | | for residents with behaviors and care plans. Systemic change is a copy of the care plan for residents with active behaviors will be kept in the front of the resident's specific medication administration sheet.<br>**Completion Date 7-13-2011**<br><br>DHS/designee will perform audits of 2 random residents to assure non-pharmacological interventions are reviewed and attempted prior to the administration of medication 5x week x one month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments<br>**Completion Date 7-13-2011** | |

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| | Medication Administration Records for May 2011 and June 1 to 13, 2011, and the PRN Medication Tracking Forms indicated the Alprazolam was given on the following dates: 5/4/11 7:30 p.m., 5/5/11 7 p.m., 5/6/11 7 p.m., 5/8/11 8 a.m. and 6 p.m., 5/9/11 8 a.m. and 8 p.m., 5/11/11 7 p.m., 5/12/11 7 p.m., 5/14/11 7 p.m., 5/15/11 7 p.m., 5/21/11 11 p.m., 5/23/11 1 a.m. 9 p.m., 6/3/11 11 p.m., 6/5/11 a.m., and 6/13/11 7 a.m. The PRN Medication Tracking Form indicated the reason given for each dose was "2." The instructions indicated "2" was anxiety (pacing, hand wringing, rocking, expressions of anxiety, etc.). There were three interventions documented as tried before the medication was given. The three interventions were a combination of the following "2-bedrest, 5-diversion, 10-social service intervene, 14-reassurance, 15-position for comfort, and 13-one on one time."<br><br>Nurses Notes dated from 4/23 through 6/13/11, lacked any documentation of anxiety or what the resident was doing prior to the administration of the Alprazolam. The Skilled Nursing Assessment and Data Collection Forms, dated daily 5/9/11 through 6/13/11, did not include any documentation under the box labeled "Mood and behavior, check | | | |

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| | all that apply." Areas to check included, but were not limited to: "Trouble falling or staying asleep, fidgeting/restless, lethargic, behavior interfere with social interactions, disrupt environment, resident rejects care...."<br><br>The Social Service Progress Notes, included entries dated 3/12/11 and 5/4/11. The 3/12/11 entry included: "resident taken Alprazolam .25 mg every 6 hours prn (as needed) for anxiety." The 5/4/11 entry indicated the resident was adjusting to new room "res voices no concerns and says yes to being pleased with new room." There were no notes concerning the resident being anxious.<br><br>During interview with RN #1 on 6/14/11 at 10:00 A.M., she indicated the facility used a behavior book for residents with behaviors. She indicated Resident #28 was not included in the book, and that Social Services created the plans in the book.<br><br>During interview with the Social Service Director, on 6/14/11 at 10:05 A.M. she indicated the resident did not currently have anxiety. She indicated she was not aware staff were giving the as needed Alprazolam or what the resident's symptoms were. | | | |

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| | During interview with LPN #3 on 6/14/11 at 1:15 p.m., she indicated she worked evening shift and had administered the Alprazolam several times in May 2011. She indicated the resident was restless, on her call light several times, would not use her communication board and staff were unable to figure out what the resident wanted. She indicated she felt the resident was much better at this time and she had not given the drug since mid May.<br><br>3.1-48(a)(6) | | | |
| R0000 | The following state residential findings were cited in accordance with 410 IAC 16.2-5. | R0000 | The submission of this Plan of Correction does not indicate an admission by Covered Bridge Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of Covered Bridge Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in | |

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| | | | substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs).To this end, this Plan of Correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. | |
| R0240 | (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences.<br>Based on observation, record review, and interview, the facility failed to insure nursing staff provided proper incontinence care for 2 of 3 residents reviewed for incontinence in a sample of 8 (Resident #101 and Resident #105)<br><br>Findings include.<br><br>1. During initial observation tour on 06/13/11 at 10:00 a.m. with QMA #1 (Qualified Medication Assistant) present Resident #101 was identified as being regularly toileted by staff but was also "always incontinent prior to toileting."<br><br>On 06/13/11 at 12:55 p.m. CNA #2 was observed to toilet Resident #101. CNA #2 was observed to remove a wet brief and to assist the resident to be seated on a commode. Resident #2 urinated a large | R0240 | R 240<br><br>Resident #101 and #105 suffered no ill effects in alleged deficient practice.<br>**Completion Date 7-13-2011**<br><br>All incontinent residents have the potential to be affected by the alleged deficient practice and through changes in provision of care and in-servicing will prevent the recurrence of the deficient practice.<br>**Completion Date 7-13-2011**<br><br>An in-service was completed for nursing staff concerning residents receiving incontinent care to have proper procedure followed. Systemic change includes all caregivers to complete return demonstration of all incontinent care skills now, and yearly thereafter.<br>**Completion Date 7-13-2011**<br><br>DHS/designee will perform audits of | 07/13/2011 |

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| | amount in the commode. CNA #2 was observed to hand the resident a piece of toilet paper and the resident wiped her bottom. CNA #2 assisted the resident to stand at a pull up bar beside the commode. The resident was observed to have reddened inner buttocks and was dripping urine from her bottom. CNA #2 was observed to not wipe the resident's bottom nor provide any type of incontinence care.<br><br>Review of Resident #101's clinical record on 06/ 13/11 at 12:00 p.m. indicated:<br><br>Resident #101 had diagnoses which included, but were not limited to, dementia, lumbar stenosis, chronic obstructive pulmonary disease, and osteoporosis.<br><br>A nurse's note, dated 05/31/11 at 11:00 p.m. indicated, "(New order) urine C&S (culture & sensitivity) then start Cipro (antibiotic medication often used to treat urinary tract infections) 250 mg (milligrams)... (twice daily) (times) 7 days. Pharmacy aware. urine obtained....2 doses of Cipro pulled from (Emergency Drug kit)."<br><br>A nurse's note, dated 06/03/11 at 5:00 a.m. indicated, "Partial culture of urine received, (no) growth after 24 (hours). | | 3 random residents who are incontinent for compliance with proper procedure 5x week x one month then 3x a week x one month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comment<br>**Completion Date 7-13-2011** | |

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| | Results faxed to (physician)."<br><br>2. During initial tour of the environment on 06/13/11 at 10:00 a.m. with QMA #1 present, Resident #105 was identified as being cognitively impaired, incontinent, and as requiring assistance from staff for toileting.<br><br>On 06/13/11 at 1:05 p.m., CNA #2 was observed to toilet Resident #105. The resident was observed to pull her own slacks down and remove a wet brief. The resident indicated "I'm taking this down." CNA #2 was observed to use 1 cleansing wipe and to swipe the resident's bottom from front to back one time.<br><br>Review of Resident #105's clinical record on 06/14/11 at 1:00 p.m. indicated:<br><br>Resident #105 had diagnoses which included, but were not limited to, dementia and diabetes mellitus.<br><br>A physician's telephone order, dated 05/14/11, indicated, "Urine C&S (Culture & Sensitivity) - Cipro (antibiotic medication often used to treat urinary tract infections) 250 (milligrams) (twice daily times 7 days).<br><br>A service plan, dated 06/09/11, indicated: Resident #105 was totally dependent on | | | |

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| | staff for hygiene and was incontinent.<br><br>A copy of a urinalysis report, dated 05/16/11, indicated Resident #105 had 3+ Leukocytes (blood cells) in her urine. The report indicated the normal range for Leukocytes in urine was "negative."<br><br>Documentation (not dated) titled "Perineal Care for the Incontinent (Resident) Guideline" was provided by the DON on 06/14/11 at 12:25 p.m. This documentation indicated, "Purpose: To provide incontinence care that will keep skin from being exposed to prolonged periods of urine and feces. Procedure -1. Residents may be cleaned using wash cloths, wet wipes or dry wipes. 2. If wash cloths or dry wipes are used peri-cleanser should be used to moisten the cloths/wipes. 3. Peri-cleanser will not be needed if using pre-moistened wet wipes unless needed to remove excessive soiling from stool...." | | | |
| R0246 | (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact.<br>Based on record review and interview, the | R0246 | R 246 | 07/13/2011 |

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| | facility failed to ensure unlicensed staff requested permission from licensed staff and documented according to facility guidelines on PRN (as needed) medications for 1 of 8 residents reviewed for medications in a sample of 8. (Resident #101)<br><br>Findings include:<br><br>Review of Resident #101's clinical record on 06/13/11 at 12:00 p.m. indicated the following:<br><br>Resident #101 had diagnoses which included, but were not limited to, dementia, chronic obstructive pulmonary disease, osteoporosis, and lumbar stenosis.<br><br>A Medication Record for May, 2011 indicated Resident #101 received (1) Hydrocodone/Apap 5/325 on 05/16/11 at 6:45 a.m. The Medication Record indicated the medication was given to the resident by QMA (Qualified Medication Assistant) #1. A "PRN (as needed) Medication Tracking" record for May, 2011 indicated Hydrocodone/Apap 5/325 was given to resident #101 by QMA #1 on 05/16/11 at 6:45 a.m.<br><br>A Medication Record for April, 2011 indicated Resident #101 received (1) | | Res # 101 suffered no ill effects from the alleged deficient practice.<br><br>**Completion Date 7-13-2011**<br><br>All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in-servicing will ensure the campus ensures unlicensed staff request permission from licensed staff and document according to campus guidelines concerning prn medication administration.<br>**Completion Date 7-13-2011**<br><br>Nursing staff have been in-serviced regarding the procedure for non licensed staff to administer prn medication. Systemic change is non licensed staff will request permission to administer a prn medication and the nurse will cosign the prn log<br>**Completion Date 7-13-2011**<br><br>DHS/ designee will review 3 random resident's prn medication log to assure compliance 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments<br>**Completion Date 7-13-2011** | |

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| | Hydrocodone/Apap 5/325 on 04/28/11 at 8:10 a.m. A "PRN Medication Tracking" record for April, 2011 also indicated Hydrocodone/Apap 5/325 was given to Resident #101 by QMA #1 on 04/28/11 at 8:10 a.m.<br><br>Resident #101's clinical record lacked documentation supporting QMA #1 contacted a licensed nursing staff prior to giving the PRN medication.<br><br>Interview of the DON (Director of Nursing) on 06/14/11 at 9:10 a.m. indicated QMA's had not been calling licensed staff prior to administering PRN medications. The DON indicated all nursing staff would be inserviced on QMA's giving PRN medications.<br><br>Documentation titled "Assisted Living Guidelines Medication Administration" and dated December 2010, was provided by the DON on 06/14/11 at 9:10 a.m. The documentation indicated, QMA's must "Administer previously ordered (PRN) medication only if authorization is obtained, the QMA must do the following: (A) Document in the resident record symptoms indicating the need for the medication. | | | |